Transition of Care

Himabindu Lanka, MD

Academic Hospitalist, Cooper University Hospital

Definition: comprehensive planning and execution of moving patients from the one health care setting to another or home based on their level of care

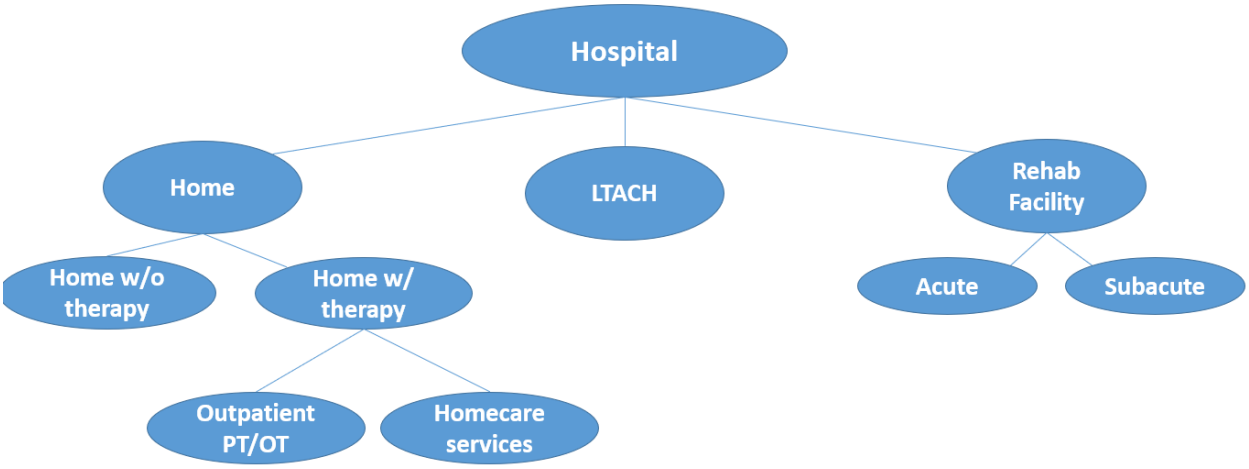

Figure 1: Transition of Care Algorithm From the hospital

Importance of Extensive focus on Transition of Care

- Current Readmission rate is 20% within 30 days
    - Communication Breakdowns: between patient and provider and hospital provider and PCP
    - Patient Education Breakdowns
        - health literacy plays a role
        - Receiving conflicting information: which leads to patients not knowing what to do upon transitioning

Who should be involved in transition of care planning?

Interdisciplinary approach with patient centered care

- Social services
- Nurses
- Patients and patients' families
- Provider (MD, NP, Pas) in the hospital
- Primary Care physician as applicable

Information to be included at discharge when patient is being transitioned from hospital to community, rehab facility or LTACH

- Reason for hospitalization
- Tests and treatments provided during hospital stay
- Instructions for what to do upon discharge
- Medications
    - New: started during the hospitalization and will be continued. Reason why it was started and duration
    - Continued home medications: note to explain if any dose changes or frequencies were changed
    - Discontinued and reason for discontinuing
- Signs and symptoms to monitor for and what to do when they occur: call PCP or go to ED
- Follow up instructions with PCP and specialists as needed
- Follow up testing as needed: communicate with PCP as appropriate

Models for Transition of Care

Better Outcomes by Optimizing Safe Transitions (BOOST): mentored implementation made by Society of Hospital Medicine

Important Pearls

- Exercise teach back with patients especially when new information is being given to them and keep it simple
- Involve families and caregivers in the discharge process especially in a complex patient with multiple co-morbidities

References

Kim, Christopher, MD, MBA, Flanders, Scott, MD. In the Clinic: Transitions of Care. Annals of Internal Medicine, 2013: ITC 3-1 to 3—14

Transitions of Care: The need for a more effective approach to continuing patient care. Joint Commission. https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf. 2012